

**New Jersey Department of Health and Senior Services  
Public Health and Environmental Laboratories  
PO Box 361  
Trenton, NJ 08625-0361**

**REQUISITION FOR VIRAL SEROLOGY**

Testing for viral serology is done on serum and cerebrospinal fluid (CSF) specimens. Please send at least 2 ml of serum and at least 1 ml of CSF for proper testing to proceed. Specimens should be maintained at 2-4° C and shipped on **ICE** to the Lab, with the **completed** form. Testing for West Nile Virus (WNV) requires acute and convalescent sera. Acute serum and CSF should be drawn 8 -10 days after onset of symptoms. Convalescent serum should be drawn 14 - 21 days after the acute sample. Red Top Tubes **ONLY**, no hemolysin. Red Top Separator Tubes are acceptable to use.

|                           |
|---------------------------|
| <b>STATE LAB USE ONLY</b> |
| Date Received             |
| Accession No.             |

*(Please print clearly with black ballpoint pen.)*

|  |                         |   |                   |   |
|--|-------------------------|---|-------------------|---|
| Patient Name (Last) (First) (MI)   |                         | DOB<br>/ /  | Age               | Sex<br><input type="checkbox"/> Male<br><input type="checkbox"/> Female |
| Street Address   |                         | City State Zip Code   |                   |   |
| <b>Onset Date</b>  | Dx or Test(s) Requested |   |                   |   |
| Attending Physician Name (Print)   |                         | Telephone Number<br>( )   | Fax Number<br>( ) |   |
| <b>SEND<br/>REPORT<br/>TO</b>  |                         |   |                   |   |
| <b>Type of Specimen and Date(s) Collected</b><br><u>SERUM</u> <u>DATE</u><br><input type="checkbox"/> Acute _____<br><input type="checkbox"/> Convalescent _____<br><input type="checkbox"/> CSF _____ |                         | <b>Travel History</b><br>Domestic (Outside NJ): <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Where (List): _____<br>When (List Date(s) of Travel): _____<br>Foreign (Outside of Continental US): <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Where (List Country, etc.): _____<br>When (List Date(s) of Travel): _____ |                   |   |
| <b>Vaccination History</b><br>Yellow Fever Vaccine: <input type="checkbox"/> Yes <input type="checkbox"/> No<br>Date(s) given (List): _____  |                         |   |                   |   |
| 1. Pertinent Clinical Information - Brief history; clinical findings; relevant lab data.   |                         |   |                   |   |
| 2. CSF Results:<br>Total WBC_____ Differential_____ %POLYS_____ %LYMPHS_____ PROTEIN_____mg% GLUCOSE_____ mg%  |                         |   |                   |   |

***Following the above criteria will help to ensure the most complete and accurate results possible. Failure to follow the above instructions and/or provide the information requested may cause delays in processing and/or indeterminate/inconclusive results.***

